STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005016	A. BUILDING: _____ B. WING _____	10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOSPITAL OF INDIANA	7950 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00154272 Substantiated; no deficiencies related to allegations are cited. Date: 10-7/8-14 Facility Number: 005016 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Lutheran Hospital of Indiana is in compliance with 410 IAC 15-1.5-1, Dietetic services, 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: claughlin 11/05/14	S 000		